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Prevalence and Correlates of Elder Abuse Among Older Women in Rural and Urban Communities in South Western Nigeria

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Elderly women face the same health, economic, and social issues that all elderly people face, but often encounter more challenges compared with men and are more prone to abuse. Elder abuse has hitherto been uncharacterized among women in South Western Nigeria. A cross-sectional survey was conducted to describe the prevalence, patterns, and factors associated with elder abuse among elderly women in Nigeria. The abuse of elderly women is quite prevalent in the two communities studied, especially physical abuse. Positive predictors of elder abuse were urban dwelling, financial dependency, and a high level of educational attainment. Appropriate interventions should be targeted toward reducing the occurrence.

Elder abuse is yet to be considered a public health problem in many developing countries and as such it is currently under-researched. Where research exists on elder abuse, it is often limited to hospital settings and carried out in developed countries. Also, few studies have explored elder abuse from the perspective of older adults in the communities (Marmolejo, 2008; World Health Organization [WHO]/International Network for Prevention of Elder Abuse [INPEA], 2002). We therefore carried out this study to provide information on the prevalence, patterns, and factors associated with abuse among elderly women in rural and urban communities in Oyo state.

Older women make up a significant proportion of the world's population and their numbers are constantly increasing. The number of women aged 60 years and above will increase from about 336 million in the year

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2000 to just over 1 billion in 2050 (WHO, 2006). In terms of proportions, older women constitute a high proportion of the population in high income countries, but with regards to sheer number, the majority of elderly women reside in low- and middle-income countries where population ageing is occurring at a rapid pace (WHO, 2006).

The health of the older woman encompasses physical, mental, and social well-being and is affected by the interaction among biological, psychological, and sociocultural influence as well as environmental and economic development (World Health Assembly, 1992; WHO, 1992). This qualitative dimension of health places an emphasis on the individual' s well-being rather than the absence of disease or infirmity and as such healthy ageing is geared toward improving both the quality and not just the quantity of life (WHO, 2004). In many societies, women are second-class citizens and suffer systematic discrimination in many areas of life. They are more likely to be poor, uneducated, have limited access to health care, be excluded from meaningful work, and live alone (WHO, 2004). This suggests that elderly women live more of their later life in poor health and suffer disabilities (WHO, 2002a).

Elder abuse is a concealed problem that is frequently cloaked under the shroud of family secrecy. In many countries worldwide, awareness is just developing that elder abuse does occur (Hurme & Aguas, 2002). Elder abuse is "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (WHO, 2002c, p. 3). It has serious health consequences and like any other form of abuse, it is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation, and despair (WHO, 2002b). Depression, suicidal thoughts, and feelings of unhappiness, shame, or guilt are common among victims of elder abuse (Bristowe & Collins, 1989; Dong et al., 2009; Phillips, 1983; Pillemer & Prescott, 1989); consequently, elder abuse has been found to be associated with increased health problems and in some cases mortality (Dong et al., 2009; Nahmiash & Schwartz, 2008). Erroneously, however, elder abuse is not usually considered as a health issue and, as such, attention is usually not targeted toward its mitigation.

Abuse varies in form and includes physical abuse, emotional abuse, financial abuse, sexual abuse, and neglect (Cohen, Halevi-Levin, Gagin, & Friedman, 2006; Collins, 2006; Nahmiash & Schwartz, 2008; WHO, 2002c). Physical abuse includes any act that involves the intentional infliction of physical discomfort and pain. Examples of physical abuse include behaviors such as restraining, slapping, kicking, cutting, or burning (Nahmiash & Schwartz, 2008; WHO, 2002c). Emotional abuse, which is sometimes referred to as verbal or psychological abuse, involves the intentional infliction of mental anguish—isolation in the older person causing psychological pain and distress (Nahmiash & Schwartz, 2008; WHO, 2002c). Emotional abuse can take various forms such as name calling, humiliation, discrimination on

the basis of age, insults, hurtful words, denigration, intimidation, and false accusations (Nahmiash & Schwartz, 2008; WHO, 2002b). Financial abuse often referred to as material abuse includes the intentional, illegal, or improper exploitation of the older person's material property or financial resources (Nahmiash & Schwartz, 2008; WHO, 2002c). Financial abuse can include fraud, theft or use of money or property without the older person's consent extortion, and control of pension money (Nahmiash & Schwartz, 2008; WHO, 2002c). Sexual abuse includes non-consensual sexual contact of any kind with the older person. This includes unwanted touching and all types of sexual battery as well as rape and coerced nudity (Nahmiash & Schwartz, 2008; WHO, 2002c). Neglect generally refers to the intended or unintended failure of a formal or informal caregiver to fulfill any part of a care-giving obligation. Neglect is said to occur in circumstances of failure to provide an older person with the necessities of life such as food, water, clothing, shelter, medicine, or comfort (Nahmiash & Schwartz, 2008; WHO, 2002c).

Several researchers have found that there are more female victims than male victims of abuse (Cooney & Mortimer, 1995; Wolf, 1997), and victims of abuse have few social contacts and often live alone (Lachs & Pillemer, 1995). Also, studies have revealed that there is increased physical and cognitive defects in elder abuse victims (Lachs & Pillemer, 1995; Steinmetz, 1988; Wolf & Pillemer, 1989). Modernization, industrialization, urbanization, and an increase in the number of women in the workforce have led to a decrease in the availability of primary caregivers for the elders and increased reports of neglect and elder abuse (Ajomale, 2007). Whilst the maltreatment and abuse of children are very well recognized, attracting a lot of public and media attention, mistreatment and neglect of older vulnerable individuals do not usually arouse the full interest and attention of the society at large. Only extreme cases are reported in the newspapers as incidents of a criminal nature (WHO/INPEA, 2002).

In Africa, there is a strong reliance on the extended family system to provide for the elderly. Social and economic changes currently occurring, however, threaten the continued viability of such traditional arrangements for the elderly. Such changes include an increasing emphasis on smaller family units, migration to urban areas, female employment, and changing values which have eroded the traditional form of caring for the elderly (Ajomale, 2007; Hoff, 2007).

METHODS

Study Area

The study was conducted in Oyo state, south western Nigeria. Oyo state according to the 2006 census has a population of approximately 5,580,894 (Oyo State Ministry of Health, 2008). The state is divided into three senatorial districts of Oyo North, Oyo Central, and Oyo South. There are 33 local

government areas (LGAs) in the state: 12 of these are urban, nine are semi urban, while 12 are located in the rural area. Over 65% of the population reside and work in the rural areas. The proportion of the elderly in the state is about 6% (National Population Commission, 2006). The study sites were Ibadan South East (urban) and Iwajowa (rural) Local Government Areas of Oyo state. The residents are mainly of Yoruba ethnicity; they are similar culturally and speak the same language, Yoruba.

Study Participants

The data for the study were obtained from a larger data set composed of males and females aged 60 years and above, in the chosen communities in both rural and urban areas of Oyo state. For the purpose of this study, adults aged 60 years and above at the time of study in the selected households were considered eligible to participate in the study. Elderly persons, who could not provide information themselves due to dementia, dumbness, deafness, or psychiatric illness or any other communication problems, were excluded from the study.

Study Design

A community-based cross-sectional design was employed using the cluster sampling technique:

Stage 1: Two local government areas, one rural (Iwajowa) and one urban (Ibadan South East) were selected by balloting from a stratified list of urban and rural LGAs in Oyo State.

Stage 2: Five wards were selected by balloting from a sampling frame of all the wards in each of the selected LGA.

Stage 3: In each of the selected wards, four settlements were selected by balloting from the list of settlements.

Stage 4: Each settlement was taken as a cluster and all consenting elderly persons, present in each household, in the selected settlements were interviewed.

Data Collection

Data were collected using interviewer administered semistructured questionnaires that were administered by trained research assistants after informed consent was obtained from the participants. Data collection took place over a 4-week period in October 2010. The questionnaire was adapted from a standardized questionnaire on elder abuse and neglect developed by the World Health Organization (WHO, 2008).

The research instrument was translated to Yoruba, the local language, for ease of communication. It was back translated to English to ensure the original meanings were maintained before administration. The questionnaire was pretested among the elderly in Ibadan North and Ibarapa North (which were not selected for the study). Following the pretest, ambiguous questions were reframed or, where necessary, deleted.

The different types of abuse were assessed by 20 questions adapted from a standardized questionnaire on elderly abuse and neglect developed by the World Health Organization (WHO, 2008). Six questions each assessed physical abuse and emotional abuse, three questions assessed financial abuse, two questions assessed sexual abuse, and one question assessed the presence of neglect. Questions on the various types of abuse experienced within 12 months of the study were scored; respondents who gave positive answers were scored 1 and negative answers were scored 0. A score of 1 or more in any category of abuse was taken as a positive experience for the type of abuse.

Depression

This was assessed using a self-rating depression scale (Bird, Macdonald, Mann, & Philpot, 1987). Scoring was made with reference to symptoms experienced over the past month. Positive responses were scored 1 and negative 0. Scores ranged between 0 and 12. Scores of 6 and above were classified as positive for depression, while scores of 5 and below were classified as negative for depression.

Assessment of Independence in Activities of Daily Living

This was assessed using the Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL (Wallace & Shelkey, 2007). The index ranked adequacy of performance in six functions, namely, bathing, dressing, toileting, transferring, continence, and feeding. Respondents were scored 1 for independence and 0 for any level of dependence in each of these six functions. The overall degree of dependency for ADLs was assessed by computing scores for the level of assistance required to carry out the fundamental activities. Maximum obtainable marks were 6.

Scoring

Scoring was as follows:

A score of 6 = full function.
A score of 3–5 = moderate impairment.
A score of 2 or less = severe functional impairment.

Self-Rated Health Assessment

This was measured by asking individuals to rate their health on a five-point scale: excellent, very good, good, fair, and poor. For analysis, this variable was dichotomized. Having less than good (i.e., fair or poor) self-rated health was categorised as perceived poor health status and those with good or better health as perceived good health status. Data were analyzed using SPSS version 16. Predictors of elder abuse were determined using logistic regression analysis. The level of statistical significance was set at 5%.

Ethical Approval

Ethical approval for the study was obtained from the Oyo State Ministry of Health Ethical Review Committee. Permission for the administration of the questionnaires was also obtained from the heads of households. Respondents were informed of their right to decline or withdraw from the study at any time without any adverse consequences, and verbal consent was obtained.

RESULTS

Respondent's Characteristics

A total of 404 elderly women were interviewed. The sociodemographic distributions are shown in Table 1. The mean age of respondents was 70.3 ±

TABLE 1 Sociodemographic Distribution of Respondents

Characteristic	Frequency	Percent
Location		
Urban	217	53.7
Rural	187	46.3
Age group (years)		
60–69	223	55.2
70–79	109	27.0
80 and above	72	17.8
Marital status		
Currently married	180	44.6
Not currently married	224	55.4
Educational status		
No formal education	294	72.8
Primary/secondary level	90	22.3
Tertiary	20	5.0
Occupational status		
Unemployed	189	46.8
Employed	215	53.2
Living arrangement		
Living alone	53	13.1
Living with family	351	86.9

8.9 years. Over half (55.2%) were aged between 60–69 years and currently employed (56.1%). Less than half were currently married (44.6%) and almost three-quarters had no formal education (72.8%). Response to questions on risk factors of abuse indicated that about 13% of the respondents were living alone; their main sources of income were reportedly through salaries (187 [86.9%]). Financial support was also provided to some of the respondents (37.6%) by their children, while 43 (10.6%) were totally dependent on family members for finances. About 22% of the respondents had health problems. The most frequently reported health problems were associated with the musculoskeletal system 166 (52.7%) followed by the cardiovascular system 61 (19.4%) and respiratory system 23 (7.3%). Less than a quarter (23.8%) of the respondents had symptoms of depression as shown in Table 2. Only six (1.5%) of the elders were fully dependent for all the ADLs put together, but in all, 172 (42.5%) of the respondents needed some assistance. Maximum dependency was observed, however, for moving around 129 (31.9%), feeding 20 (5.0%), and bathing 23 (5.7%).

TABLE 2 Financial Situation, Self-Rated Health Assessment, and Pattern of Health Problems Among the Respondents

Characteristic	Frequency	Percent
Financial situation		
Financially self-sufficient	361	89.4
Financially dependent	43	10.6
Self-rated assessment of health		
Very good	58	14.4
Good	176	43.6
Average	151	37.4
Below average	19	4.6
Existing health problems		
Present	315	78.0
Absent	89	22.0
Depression		
Present	96	23.8
Absent	308	76.2
Type of health problem		
Musculoskeletal	166	52.7
Cardiovascular	61	19.4
Respiratory	23	7.3
Eye	20	6.3
Central nervous system	15	4.8
Others**	30	9.5
Maximum dependency for ADL		
Moving around	129	75.0
Bathing	23	13.4
Feeding	20	11.6

**Others include diseases of the gastrointestinal system; ear, nose, and throat; dental; and endocrine problems.

TABLE 3 Characteristics of Respondents and Occurrence of Elder Abuse

Variable	Abuse Yes	No	*p* value
Location			
Urban	91 (41.9)	126 (58.1)	
Rural	30 (16.0)	157 (84.0)	.000*
Age group (years)			
60–69	47 (21.1)	176 (78.9)	
70–79	42 (38.5)	67 (61.5)	
80 and above	32 (44.4)	40 (55.6)	.000*
Marital status			
Currently married	43 (23.9)	137 (76.1)	
Not currently married	78 (34.8)	146 (65.2)	.011*
Occupational status			
Currently unemployed	76 (40.2)	113 (59.8)	
Currently employed	45 (20.9)	170 (79.1)	.000*
Living arrangement			
Living alone	23 (43.4)	30 (56.6)	
Living with family	98 (27.9)	253 (72.1)	.018*
Financial situation			
Financially self-sufficient	230 (74.2)	80 (25.8)	
Financial dependence	48 (54.5)	40 (45.5)	.000*
Functional impairment			
Yes	27 (45.8)	32 (54.2)	
No	94 (27.2)	251 (72.8)	.004*

*p value statistically significant.

The overall prevalence of any type of elder abuse was 30%: physical abuse (14.6%) was the most frequently occurring type followed by financial abuse (13.1%) and emotional abuse (11.1%). Only 7 (1.2%) of the elderly reported neglect, while 2 (0.04%) respondents reported sexual abuse. In many instances, children were the most likely perpetrators of physical abuse (43.7%), emotional abuse (40.5%), and neglect (83.3%). Neighbours and cotenants (47.6%), however, were the main perpetrators of financial abuse.

On bivariate analysis, significantly, higher proportions of respondents who were urban dwellers, living alone, unmarried, unemployed, aged between 60 and 69 years, financially dependent, and who had functional impairment experienced abuse ($p < .05$) as shown in Table 3. Positive predictors of elder abuse on logistic regression analysis follow: urban dwelling [OR: 3.4 (95% CI: 2.05–5.74)]($p = .000$); financial dependence [OR: 2.2 (95% CI: 1.18–3.93)] ($p = .012$); and high level of educational attainment [OR: 2.93 (95% CI: 1.03–8.3)] ($p = .042$).

DISCUSSION

Globally, elder abuse is rapidly becoming a recognized social and public health problem that threatens the health of elderly people (Lachs & Pillemer,

2004; WHO, 2002c). In this study, the overall estimate of reported elder abuse within 12 months preceding the study in the population was 30%. This is higher than has been documented by studies from other countries (Eisikovitz, Winterstein, & Lowenstein, 2005; Eriksson, 2001; Sherman, Rosenblatt, & Antonucci, 2008; Yan & Tang, 2001). In Sweden, national estimates of elder abuse indicate that about 13% of men and 16% of women aged 65 years and above reported experiencing abuse (Eriksson, 2001; Sherman et al., 2008). Similarly, in a national survey among Israeli elders, over 18% of elders experienced abuse (Eisikovitz et al., 2005). A study in Hong Kong revealed that among the respondents 21% have experienced at least an instance of abuse within the past year (Yan & Tang, 2001). Another study in China estimated that 35% of the study population had experienced abuse although it was conducted in urban health centers. (Dong, Simon, & Gorbein, 2007). The difference in prevalence between reported studies and our study may be because the population in our study is composed of elderly women in a low-income country who are recognized to have various social disadvantages by virtue of their gender.

Demographic characteristics such as being unmarried, having low educational attainment and low income have been repeatedly documented to be associated with elder abuse (Acierno et al., 2010; Lachs & Pillemer, 1995; Marmolejo, 2008; Tareque, Islam, & Rahman, 2008), and similar findings were reported in this study. This is not unusual because higher proportions of the respondents had these qualities and are therefore more prone to risk of abuse. Furthermore, living alone increases the risk of abuse as documented in our study and compared with similar studies (Acierno et al., 2010; Lachs & Pillemer, 1995; Marmolejo, 2008; Podnieks, 1992; Wolf & Pillemer, 1989). In our study, the majority of the abused persons were among the oldest old, which supports the prevailing view that the oldest old are the most vulnerable group who are maltreated as reported by other studies (Marmolejo, 2008; Tareque, Islam, & Rahman, 2008; Tatara, 1998).

In this study, physical abuse was the most prevalent form of abuse reported by the women. This is contrary to reports from other surveys where emotional abuse was usually the most frequently documented type of abuse experienced (Chokkanathana & Lee, 2006; Ogg & Bennett, 1992; Pillemer & Finkelhor, 1988; Steinmetz, 1988; Yan & Tang, 2001). Emotional abuse was also high in the study. This may be because in the traditional African society, there is a high level of respect for the elderly. Furthermore, culturally, there are accepted ways of addressing the elderly and as such any deviation from the norm will be highly noticeable.

Limitations of the Study

The prevalence of abuse was from self-reports and there were no measures to substantiate the reports. As such the unusually high prevalence of

abuse compared with other previous studies might indicate over-reporting, especially in the absence of any relationship with depression. Respondents may have given responses to make us more empathetic with their condition.

CONCLUSION

This study has revealed that elder abuse among older women is not uncommon in these communities. All forms of elder abuse are quite prevalent except sexual abuse. Financial insufficiency and poor social support are contributory factors. Appropriate social welfare interventions are required to ameliorate the problem.

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